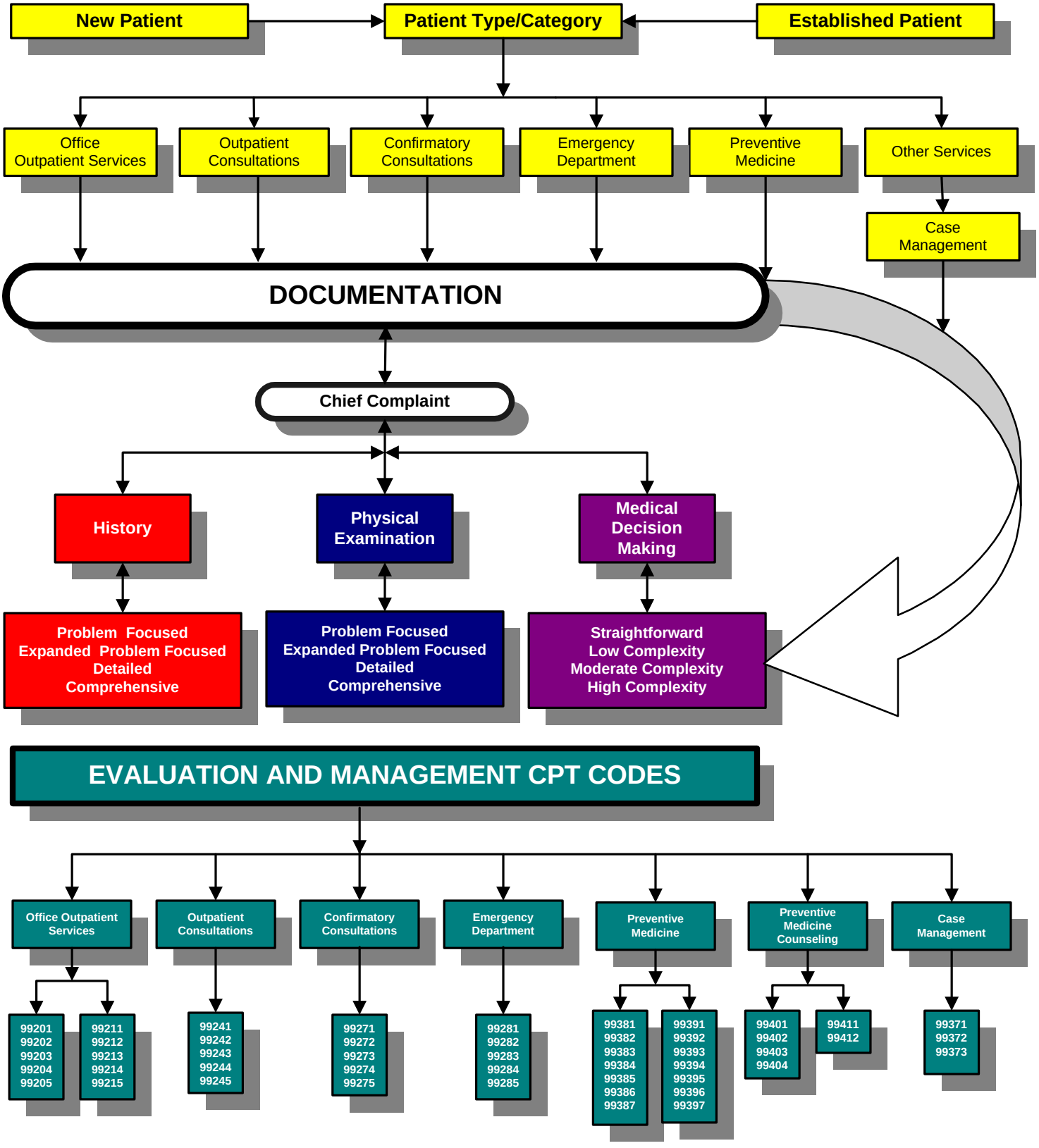
EVALUATION AND MANAGEMENT FLOWCHART



CPT Evaluation and Management

Introduction

This CPT Evaluation and Management (E/M) Self-Study manual was created to assist physicians in understanding the critical nature of medical record documentation in determining an E/M code, which is descriptive of the services provided for the patient.

- ✧ Documentation in the medical record describes the acuity of the patient;
- ✧ Documentation in the medical record describes the expertise utilized to provide care; and
- ✧ Documentation in the medical record substantiates care was provided.

The documentation functions are incorporated with CPT E/M coding theory to accomplish the goal of this manual; therefore, an understanding of the CPT E/M coding theory is essential.

Although the CPT E/M coding process is highly complex, each component of the process is discussed and examples are provided to reinforce the theories. As you read the manual, please remember the intent is not to influence how you provide care to your patients. The purpose of this self-study manual is to methodically explain the multifaceted rules of the coding process, and provide you with tools, which will ensure adequate documentation and appropriate selection of a CPT E/M code. By understanding the coding process, recording adequate medical record documentation to support the selected E/M Code will become second nature.

The manual is divided into the following sections:

- ➢ Introduction:
  - ◆ Provides goals and objectives;
  - ◆ Identifies the IFMC role in the creation of the manual; and
  - ◆ Defines medical record documentation requirements.

- ➢ Patient Type/Category:
  - ◆ Focuses only on the outpatient setting, due to the data reporting constraints of the Military Health Systems (MHS);
  - ◆ Provides definitions of new patient versus established patient; and
  - ◆ Defines the category of services.

- ➢ Patient History:
  - ◆ Defines chief complaint;
  - ◆ Defines the history documentation elements:
    - Past patient, family, and social history;
    - History of present illness; and
    - Review of systems.

- ➢ Physical Examination:
  - ◆ Defines the term physical examination;
  - ◆ Defines the type/degree of physical examination;
  - ◆ Provides a list of the body systems utilized in the physical examination; and
  - ◆ Defines the documentation components of examination within each body system.

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- Medical Decision Making:
  - Defines Medical Decision Making utilizing:
    - Management options,
    - Data reviewed, and
    - Level of risk.
  - Defines the types/degree of medical decision making.

- CPT E/M Codes:
  - Provides the rules for selection of outpatient CPT E/M codes.
  - Provides Code Finder tables for selection of CPT E/M codes.

- Bibliography

- Worksheets:
  - Blank worksheets, for each body system, are provided.

Each section of the manual displays a color-coded flow chart to focus on the component discussed in the chapter. In addition, all E/M coding sections provide case scenarios to reinforce the learning process. The worksheets are tools designed for you to use. Please feel free to copy the worksheets.

Goals and Objectives

Goal:
The CPT E/M self-study manual was created to assist physicians in understanding the critical nature of medical record documentation required to describe the acuity of the patient, the degree of expertise utilized to provide care, and the care provided.

Objectives:
Upon completion of the self-study manual you will be able to:

Classify:
- Patient type:
  - New patient and
  - Established patient.
- The category of outpatient service provided:
  - Physician Office,
  - Consultation,
  - Emergency Department,
  - Preventive Medicine, and
  - Case Management.

Goals and Objectives (Continued)

Identify and record:
- The chief complaint and
- Documentation of the three (3) elements of the patient history:
  - History of present illness,
  - Review of systems, and
  - Past patient, family, and social history.

Select:
- The type of history based on documentation:
  - Problem focused,
  - Expanded problem focused,
  - Detailed, and
  - Comprehensive.

Identify and record:
- Documentation components of physical examination and
- Documentation using the correct body system and rules.

Select:
- The type of physical examination based on documentation:
  - Problem focused,
  - Expanded problem focused,
  - Detailed, and
  - Comprehensive.

Identify and record:
- The types of medical decision making:
  - Straightforward,
  - Low complexity,
  - Moderate complexity, and
  - High complexity.

Classify:
- The key components and know the documentation requirements for each level of the key components:
  - History,
  - Physical examination, and
  - Medical decision making.

Assign:
- Appropriate CPT E/M code(s) for services documented and provided.

Introduction

The Iowa Foundation for Medical Care

The Iowa Foundation for Medical Care (IFMC), as the Medical Review Information Center (MRIC), has been a Department of Defense (DoD) contractor since 1991. The IFMC collaborates with military health systems (MHS) including Health Affairs, Lead Agents, Military Treatment Facilities (MTFs), and military clinics worldwide. Services provided by the IFMC include:

- Database validation,
- Ambulatory Data System (ADS) audits comparing current procedural terminology (CPT) coding and medical record documentation;
- Management Information System (MIS) reports utilizing standard inpatient data record (SIDR) and standard outpatient data record (SADR);
- CPT EM coding training; and
- Utilization and quality management training.

At the request of DoD and numerous Lead Agents, IFMC performed database validation and medical record review of military outpatient clinics. The validation review consistently revealed a low compliance with CPT E/M coding conventions and the Health Care Financing Administration (HCFA) documentation guidelines for E/M code assignments. Low compliance appeared to occur because the extent and contents of documentation did not support the level of E/M codes assigned for outpatient services. Therefore, the IFMC has recognized the need for E/M coding education and has organized this self-study manual, which incorporates both American Medical Association (AMA) CPT coding rules and HCFA's 1997 Documentation Guidelines for Evaluation and Management Services.

Disclaimer

This manual is a resource guide to assist military medical practitioners with the assignment of CPT E/M codes in the rapidly changing medical practice environment. The information presented is based upon the experience and research performed by the IFMC Information Systems (IS) staff. In the complex, rapidly changing medical practice environment, our opinions may or may not prove to be correct.

Decisions should not be based solely upon information within this guide. Decisions impacting your practice must be based upon legal/ethical considerations and new or pending military government regulations.

This guide does not contain a complete reprint of the CPT manual or the HCFA 1997 Documentation Guidelines for Evaluation and Management Services. Therefore, you should not code directly from this manual. A new CPT manual should be reviewed annually to ensure there have been no changes. In addition, the HCFA Documentation Guidelines for Evaluation and Management Services should be reviewed for changes or additions to the guidelines.

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By accepting and using this manual, the user agrees that neither IFMC, nor its officers, employees or agents shall have any responsibility or liability for any errors or omissions in this manual. Without limiting the generality of the foregoing, IFMC, its officers, employees and agents do not assume any responsibility or liability for any adverse outcome from using this manual for any reason including, but not limited to, undetected errors, opinion and analysis which might prove inaccurate or incorrect, or the reader's misunderstanding or misapplication of the information.

Medical Record Documentation

"Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes."[1] The medical record should chronologically document the care of the patient, as this is an important element contributing to high quality care.

Documentation in the medical record should reflect key pertinent issues identified and considered by the physician in determining the type of services, which will be provided to the patient. As noted in the following HCFA documentation guidelines, "the nature and amount of physician work and documentation varies by the type of service." For instance, if the nature of the type of service provided to the patient does not require documentation of the patient history and/or a physical examination is not necessary; then these items would not be documented. However, if a CPT E/M code is reported, which suggests a patient history was obtained and/or a physical examination was performed; then the documentation must be present in the medical record.

The extent of physician effort and documentation varies by the type of service, place of service, and the patient's status. Following are standard rules and principles for documentation.

- "The medical record should be complete and legible.
- Documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings, and diagnostic test results;
  - Assessment, clinical impression or diagnosis;
  - Plan for care; and
  - Date and legible identity of the observer.
- The rationale for ordering diagnostic and other ancillary services should be easily inferred, if not documented.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented."[2]
- The CPT and ICD-9-CM codes selected from the "bubble sheets" for ADS data collection must be supported by documentation in the medical record.

[1] HCFA, 1997 p. 2
[2] Ibid., p. 3